Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers of Intellectual Disability, Individual and Family Developmental Disabilities Support and Day Support Waiver Services

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 5/24/2016

SUBJECT: Developmental Disabilities Medicaid Waivers Redesign

This is the first in a series of Medicaid Memos designed to provide information regarding proposed changes to the Medicaid 1915(c) Home and Community Based Services (HCBS) waivers serving individuals with any developmental disability, including intellectual disability. This communication outlines the scope of the changes that have been authorized and funded by the General Assembly and have been submitted to the **Centers for Medicare and Medicaid Services** (CMS) for approval. These changes, subject to CMS approval, will be implemented on or about July 1, 2016 or as soon as the waiver amendments have been approved by CMS.

Since July 2013, the Department of Medical Assistance Services (DMAS) and the Department of Behavioral Health and Developmental Services (DBHDS) have worked collaboratively with individuals with developmental disabilities (DD), families, advocates, public and private providers, community and state-based agencies, as well as national consultants to streamline the current waivers and develop services that support living full and integrated lives in the community. The work undertaken to achieve this goal is part of the larger initiative focused on community inclusion, opportunity and choice for people with DD, *My Life, My Community*.

This system transformation is intended to achieve consistency, equity, quality, and accountability across waivers. This transformation will help to ensure that Virginia's resources support all individuals with DD and respond to the CMS Home and Community Based Services (HCBS) federal regulations which require that individuals receiving waiver services live, work, and utilize services in integrated community settings.

The changes permit:

- All individuals with DD to follow the same process to qualify for and access services and supports;
- The provision of services, supports and funding based on individual needs; and
- The establishment of revised rates and enhanced choice of services and providers.

The three current DD waivers proposed for amendment and subject to CMS approval are as follows:

- The **Intellectual Disability (ID) Waiver** will become the **Community Living Waiver**, which will include residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs.

- The **Individual and Family Developmental Disabilities Support (DD) Waiver** will become the **Family and Individual Supports Waiver** which will include supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.

- The **Day Support Waiver** will become the **Building Independence Waiver** which will include supports for adults (18+) who live independently in their own homes. Services may be complemented by non-waiver funded rent subsidies and/or other types of support.

All three waivers, as amended, will serve individuals with a diagnosis of DD. Individuals with any developmental disability seeking waiver services will have diagnostic and functional eligibility assessed by their local Community Services Board (CSB) and, as appropriate, be placed on a single state wide waiting list. Local waiver waiting lists will be maintained by the CSBs for all individuals under their jurisdiction, including those served by private DD case management agencies.

Once the transition to the new waivers occurs, individuals will seamlessly shift to the needs-based successor waiver corresponding to their present waiver as described above. An exception to this will be youth under 18 on the Day Support Waiver, who will be transitioned to the Family and Individual Supports Waiver.

The following services will be available in each waiver:

SERVICES	Building Independence Waiver	Family and Individual Support Waiver	Community Living Waiver
Shared Living	X	X	X
Group Home Residential			X
Sponsored Residential			X
Supported Living Residential		X	X
In Home Supports		X	X
Independent Living Supports	X		
Community Engagement	X	X	X
Community Coaching	X	X	X
*Community Guide/Peer Mentoring	X	X	X
Group Day Services	X	X	X
Individual Supported Employment	X	X	X
Group Supported Employment	X	X	X
Workplace Assistance Services		X	X
Private Duty Nursing Services		X	X
Skilled Nursing Services		X	X
Therapeutic Consultation		X	X
Crisis Support Services	X	X	X
Center-based Crisis supports	X	X	X
Community-based Crisis Supports	X	X	X
Personal Assistance Services		X	X
Respite Services		X	X
Companion Services		X	X
PERS	X	X	X
Assistive Technology	X	X	X
Environmental Modifications	X	X	X
Individual and Family/Caregiver		X	

SERVICES	Building Independence Waiver	Family and Individual Support Waiver	Community Living Waiver
Training			
Transition Services	X	X	X
Electronic Home-Based Supports	X	X	X
Services Facilitation		X	X
*Benefits Planning	X	X	X
*Non-Medical Transportation	X	X	X

*Services noted with an asterisk have a delayed implementation date of July 2017.
** Prevocational Services are being eliminated as a waiver service effective July 1, 2016. If you are a provider transitioning from this service model and would like to seek assistance, contact the DBHDS Director of Community Supports, Heather Norton, at heather.norton@dbhds.virginia.gov.

As part of the amended waivers, certain services will be reimbursed according to a tiered structure. Tiers are based on the level of support needed by the individual, as determined by the SIS. Various residential services (e.g., group home and sponsored residential), as well as other services (e.g., group day, community engagement, and group supported employment) will require a tiered reimbursement schedule based on the expected number of hours of direct supervision and support that an individual may need. The reimbursement tiers are tied to individuals' supports levels as determined by the SIS, so that service providers are reimbursed at a higher amount for supporting individuals with greater needs. The rate structure also reflects higher reimbursement for more integrated and/or smaller settings. Providers will bill the appropriate tier for individuals they support.

The first two tiers are directly tied to the first two supports levels, while Tiers 3 and 4 are associated with multiple supports levels. Figure 1.0 illustrates the levels and tiers in a graph format; Figure 2.0 illustrates the relationship between levels and tiers and the projected percentage of individuals in the current waiver population who are expected to fall into each level.

Figure 1.0: Relationship of Individual Support Levels to Reimbursement Tiers

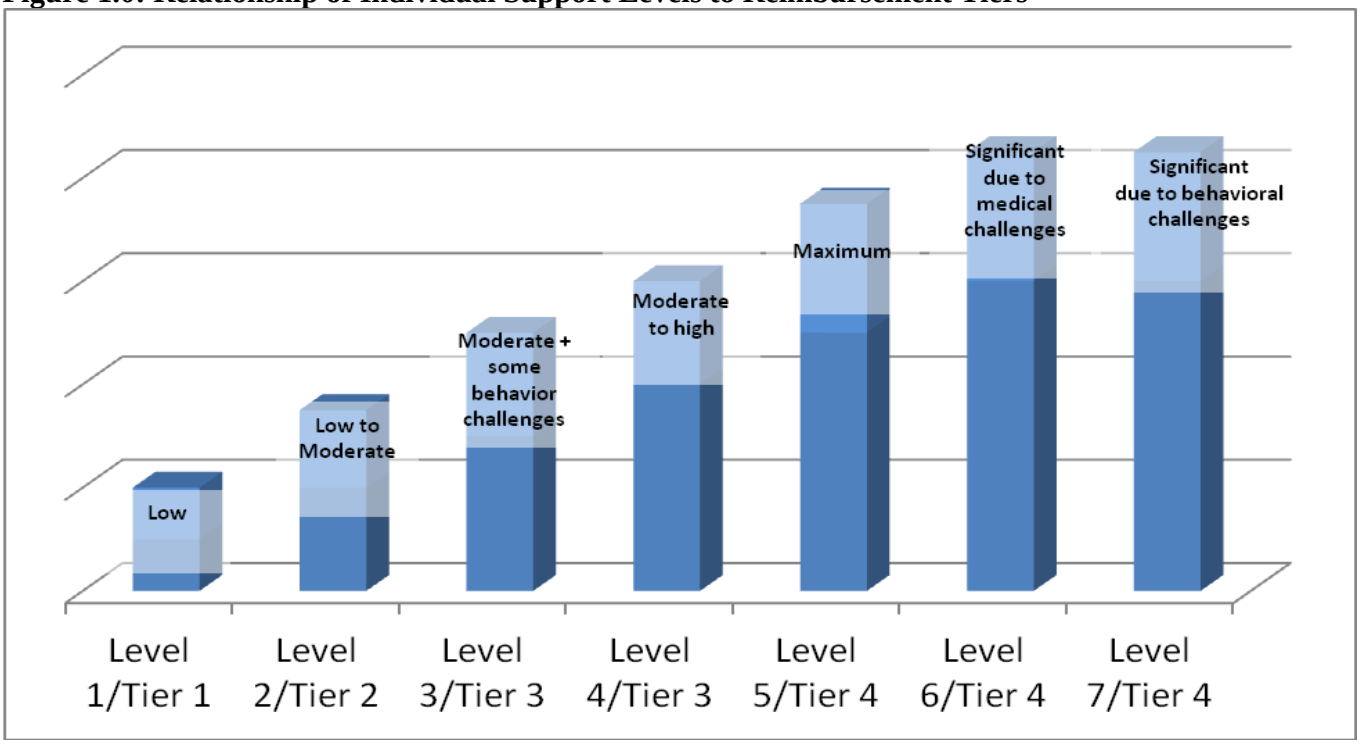

Figure 2.0: Reimbursement Tiers and Corresponding Supports Needs Levels

Tiers	Levels		# of Individuals	%
①	❶	Mild Support Needs	840	7.3%
②	❷	Moderate Support Needs	4,360	37.9%
③	❸	Mild/Moderate Support Needs with Some Behavioral Support Needs	276	2.4%
	❹	Moderate to High Support Needs	4,452	38.7%
④	❺	High to Maximum Support Needs	610	5.3%
	❻	Intense Medical Support Needs	794	6.9%
	❼	Intense Behavioral Support Needs	173	1.5%

The current proposed timeline for implementation of the amended waivers appears below:

- **Upon approval by CMS** (anticipated to be on or about July 1, 2016)**,** the **Building Independence**, **Family & Individual Supports,** and **Community Living** waivers will come into operation**.**
- **In July 2016,** the new Group Home rate structure (daily billing vs. the current hourly billing) and tiered rate structure for the following services will be available: group home residential, supported living residential, group day, and community engagement. All other new services (other than

those indicated with an asterisk above) will be available at this time or upon approval of the waiver amendments by CMS.

- **In January 2017**, the **new Sponsored Residential tiered rate structure** will take effect.
- **In July 2017**, other new services indicated with an asterisk above will be available, pending approval by CMS and the General Assembly.

DMAS will publish four additional memos prior to the July 1, 2016 implementation with information for providers. The first three memos will cover detailed service definitions and billing information (procedure codes, units and rates) for residential services, day services and other waiver services for new and modified services or existing services with new rates. The fourth memo will cover service authorization changes. There is also a separate memo, which includes rate changes to personal care, respite care and companion care services available in many waivers. There are no services or rate changes to PERS, Assistive Technology, Environmental Modifications, Individual and Family/Caregiver Training, Transition Services or Service Facilitation.

As additional information, the following represent Medicaid Memos that are anticipated to be released between now and next March related to the efforts discussed:

Waiver Redesign related to MMIS changes, procedure codes, reimbursement, etc
Medicaid Memo #1: Introduction Memo regarding Waiver Redesign overall
Medicaid Memo #2: Residential Service Oriented Memo to cover redesign service definitions/descriptions and procedure codes/rates/units
Medicaid Memo #3: Day Service Oriented Memo to cover redesign service definitions/descriptions and procedure codes/rates/units
Medicaid Memo #4: Ancillary (other) Service Oriented Memo to cover redesign service definitions/descriptions and procedure codes/rates/units
Medicaid Memo #5: Memo to cover service definitions/descriptions and procedure codes/rates/units related to personal care, respite and adult day health- not specific to redesign but effects rates in the DD waivers
Medicaid Memo #6: Memo to cover service authorization processes and requirements for the previous Medicaid Memos #2-4
Medicaid Memo #7: Released in late Fall 2016 Sponsored Residential Services taking effect 1/1/17 to cover service definition/description, procedure codes/rates/units and service authorization requirements
Medicaid Memo #8: Released in early Spring 2017 New services to begin July 1, 2017 to cover service definition/description, procedure codes/rates/units and service authorization requirements

DD Case Management Transition to CSBs
Memo to include information about the single point of entry and general transition process as well as the rate change

ADDITIONAL INFORMATION ON THE MEDICAID WAIVER REDESIGN:

DBHDS website
http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a managed care program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

MANAGED CARE PROGRAMS

Many Medicaid individuals are enrolled in one of the Department's managed care programs (Medallion 3.0, CCC and PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.